Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

Respondent Name:
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number:
M4-12-0893-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I mailed the enclosed to the wrong address/department; the DWC report along with multiple correspondence. Liberty Mutual is refusing to pay any bills & is ignoring all communication from my doctor."

Amount in Dispute: $755.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1st response to MDR #M4-12-0893-01 for.. This dispute requires further review by the claims case owner and a response will be sent ASAP"

Response Submitted by: Liberty Mutual Insurance Co. Irving, TX

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 17, 2010 May 28, 2010 June 8, 2010 November 12, 2010	Out-of-Pocket Medical Expenses	$717.27	$0.00
December 3, 2010 February 2, 2011 March 25, 2011 May 11, 2011 August 15, 2011 August 31, 2011	Out-of-Pocket Medical Expenses	$43.77	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes: The insurance carrier did not submit EOB(s) to the injured worker nor did

Issues

1. Did the requestor timely file the disputed dates of service in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit the receipts for the services to the insurance carrier in accordance with 28 Texas Administrative Code §133.270?
3. Did the insurance carrier, or its agent, respond to the request for reimbursement to the injured worker in accordance with 28 Texas Administrative Code §133.270(c)?
4. Is the requestor entitled to reimbursement?

Findings

1. The Division received the medical fee dispute request via fax on November 17, 2011. In review of the disputed dates of service listed on the Table of Disputed Services, the Division finds that dates of service May 17, 2010, May 28, 2010, June 8, 2010 and November 12, 2010 do not meet the timely filing requirements of 28 Texas Administrative Code §133.307(c)(1)(A) and are not eligible for review by Medical Fee Dispute Resolution. Dates of service December 3, 2010, February 2, 2011, March 25, 2011, May 11, 2011, August 15, 2011 and August 31, 2011 were submitted in accordance with the rule and will be reviewed in accordance with the Act and Division Rules.
2. The requestor did not submit documentation to support the timely out-of-pocket expenses were sent to the insurance carrier for reimbursement in accordance with 28 Texas Administrative Code §133.270(a and b) which states: (a) An injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in: (1) Insurance Code §1305.451, or (2) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the

Injured Employee). (b) The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider.

3. In communicating with the injured employee, he states that he has never received any written communication or EOBs. The carrier response to the request for medical fee dispute resolution was received in the Division on December 5, 2011. As documented in the Respondents' position summary a second response has not been received as of February 8, 2012.
4. Because the requestor did not support that the timely dates of service were submitted to the carrier for reimbursement prior to filing for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.270, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 13, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).